

2023-2024 Cancellation Request Form

School of Dentistry Residents and Fellows

Cancellation request form for residents and fellows in job codes 9552 and 9553. To cancel coverage, please complete and return this form to the Office of Student Health Benefits. Please keep a copy for your records. If you are requesting to cancel coverage outside of open enrollment, you must provide a certificate of coverage from your new insurance provider within 30 days of the start date of the new coverage.

A. Resident/Fellow Information

Name (last, first, middle initial) <i>(please print)</i>	Date of birth (mm/dd/yyyy)	U of M ID number
Street address, city, state, ZIP code	Daytime phone	Email address

B. Cancellation Information

Cancel medical plan – you are also required to submit the Health Insurance Waiver Request form and a certificate of coverage from your new insurance provider

Cancel dental plan

To cancel COBRA coverage, please contact BRI directly 866-996-5200, Extension 1, or participantservices@benefitresource.com.

C. Please name all persons whose coverage you would like to cancel

Resident/Fellow

Spouse	Name (last, first, middle initial) <i>(please print)</i>	Date of birth
Child	Name (last, first, middle initial) <i>(please print)</i>	Date of birth
Child	Name (last, first, middle initial) <i>(please print)</i>	Date of birth

If more than two children, please use the back of this form.

D. Resident/Fellow Acknowledgement

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give the University of Minnesota, any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of us the use of my U of M ID number for the purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by us on this application may invalidate my and/or my dependent's coverage.

Resident/Fellow signature (electronic signatures are not accepted)	Date signed
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